DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 6 — 2 5

2. STATE: New York

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
April 1, 1996

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR Part 447

7. FEDERAL BUDGET IMPACT:
a. FFY 1995-1996 $ -23.64m
b. FFY 1996-1997 $ -51.66m

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B Pages 1(b),1(b)(1),1(c),1(d), 1(e),2(a),2(b),2(c),4,7(a),7(a)(1),14

SEE REMARKS

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B Pages 1(b),1(b)(1),1(c), 1(d),1(e),2(a),2(b),2(c),4,7(a),14

No Previous Page: Attachment 4.19-B Page 7(a)(1)

10. SUBJECT OF AMENDMENT:
Outpatient Services

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Miriam J. Vilar

14. TITLE:
Acting Commissioner

15. DATE SUBMITTED:
June 27, 1996

16. RETURN TO:
New York State Department of Social Services
40 North Pearl Street
Albany, New York 12243

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUN 2 8 1996

18. DATE APPROVED: AUG 1 5 2000

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
April 1, 1996

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Sue Kelly

22. TITLE:
Associate Regional Administrator, Division of Medicaid and State Operations

23. REMARKS:
As a result of numerous changes made by the STate to the original submission, this final approval consists of Attachment 4.19B Pages 1(d), 1(e), 2(a), 2(b),2(c),2(c)(i), 4, and 14.

FORM HCFA-179 (07-92)

Instructions on Back

capital cost component. For fiscal year ending March 31, 1994, such rates are trended and extended to September 30, 1994. Commencing October 1, 1994 and thereafter, such rates shall be calculated as above for fiscal years beginning October 1, and ending September 30 except that rates of payment for the period ending September 30, [for the period ending] 1995 shall continue in effect [~~through September 30, 1996~~] thereafter MMTP services may be reimbursed on a uniform fixed weekly fee per enrolled patient basis. Payment rates for renal dialysis services of $150.00 per procedure are adjusted to reflect utilization patterns for CAPD, CCPD, hemodialysis and extended peritoneal dialysis services. A single price per visit for day health care services rendered to patients with acquired immunodeficiency syndrome (AIDS) and other human immunodeficiency virus (HIV) related illnesses is determined based on reasonable projections of necessary costs and utilization and trended to later rate years. Price components may be adjusted for service capacity, urban or rural location and regional differences. Rates are subject to approval of the Division of the Budget.

Designated Preferred Primary Care Provider for Freestanding Diagnostic and Treatment Centers

Freestanding diagnostic and treatment centers seeking reimbursement as designated preferred primary care providers are required to enter into a provider agreement with the New York State Department of Health.

Reimbursement for providers designated as preferred primary care providers is prospective and associated with resources use patterns to insure that ambulatory services are economically and efficiently provided. The methodology is based upon the Products of Ambulatory Care (PAC) classification system.

Under the reimbursement method, facility specific payment rates are established for each of the PAC groups. For each service a rate is established to cover all labor, ancillary services, medical supplies, administrative overhead, general and capital costs. A supplemental capital add-on is available to facilities participating in the preferred primary care program which finance capital acquisitions through public authorities.

The rates are regionally adjusted to reflect differences in labor costs for personnel providing direct patient care and clinic support staff. The rates have been set prospectively by applying an economic trend factor, except that rates of payment for the period ending September 30, 1995 shall continue in effect ~~[through September 30, 1996]~~ thereafter.

A supplemental bad debt and charity care allowance will be established annually for diagnostic and/or treatment centers approved as preferred primary care providers and paid as an addition to the facility's rate of payment. Each facility's allocation shall be based on its losses associated with the delivery of bad debt and charity care and computed on the basis of projected and allowable fiscal and statistical data, adjusted to actual, submitted by the facility. The amount paid per visit shall be based on each facility's allocation divided by projected Medicaid threshold visits adjusted to actual visits. Notwithstanding any inconsistent provision of this paragraph, adjustments to rates of payment for diagnostic and treatment centers for such supplemental bad debt and charity care allowance shall apply only for services provided on or before December 31, 1996.

For services provided on or after April 1, 1995 by providers designated as preferred primary care providers, rates of payment may be established pursuant to the reimbursement payment methodology described in this section only for services provided by providers which submitted bills prior to December 31, 1994 based on the reimbursement payment methodology described in this section, or by a diagnostic and treatment center operated by a general hospital designated as a financially distressed hospital, which applied on or before April 1, 1995 for designation as a preferred primary care provider. The reimbursement payment methodology described in this section is an alternative to the prospective average cost per visit reimbursement method used for non-participating diagnostic and treatment centers. There are unique features present in the reimbursement program designed to encourage provider participation and foster quality of care. The most notable of these is the financial

Hospital Based Ambulatory Surgery Facilities Certified Under Article 28 of the Public Health Law

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, and space occupancy and plant overhead costs, and an economic trend factor is applied to make the prices prospective.

Freestanding-Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Ambulatory Surgery Centers

Case based rates of payment have been calculated for the Products of Ambulatory Surgery Payment groups. All procedures within the same payment group are reimbursed at a single discrete base price. The applicable base price for each payment group is adjusted for regional differences in wage levels, and space occupancy and plant over-head costs, and an economic trend factor is applied to make the prices prospective. The agency may pay the usual and customary rates of such medical facilities or approved services but must not pay more than the prevailing rates for comparable services in the geographic area.

Attachment 4.19B
(6/96)

Hospital Based Outpatient Department

**Facilities Certified Under
Article 28 of the Public Health Law**

**Services for AIDS and HIV
positive patients**

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

**Freestanding Diagnostic
and Treatment Centers**

**Facilities Certified Under
Article 28 of the Public Health
Law As Freestanding
Diagnostic and Treatment Centers**

Services for AIDS and HIV positive patients

Visit based rates of payment have been calculated for five discrete clinic services provided to AIDS and HIV positive patients. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect [~~through September 30, 1996~~] thereafter.

TN 96-25 Approval Date AUG 15 2000

Supersedes TN 95-25 Effective Date APR - 1 1996

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Attachment 4.19B
(6/96)

Hospital Based Outpatient Department Facilities Certified Under Article 28 of the Public Health Law as Hospital-Based Outpatient Departments

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective.

Freestanding Diagnostic and Treatment Centers

Facilities Certified Under Article 28 of the Public Health Law as Freestanding Diagnostic and Treatment Centers

Services for Pregnant Women

Visit based rates of payment have been calculated for three discrete clinic services provided to pregnant women. For each service a discrete price has been established. The prices have been regionally adjusted to reflect regional differences in labor and facility overhead costs and an economic trend factor has been applied to make the prices prospective, except that rates of payment for the period ending September 30, 1995 shall continue in effect [~~through September 30, 1996~~] thereafter.

TN 96-25 AUG 15 2000

Supersedes TN 95-25 Effective Date APR - 1 1996

Comprehensive Primary Care Services

Voluntary Non-Profit and Publicly Sponsored Diagnostic and Treatment Centers Certified Under Article 28 of the Public Health Law

An allowance will be established annually and added to Medicaid rates of payment for certified agencies which can demonstrate a financial shortfall as a result of providing comprehensive primary care services to a disproportionate share of uninsured low-income patients. Losses will be calculated by applying the current Medicaid payment rate to base year units of service to uninsured low-income patients, offset by related-out-of-pocket patient receipts, subsidy grants and State aid deficit financing to publically-sponsored facilities. An annual agency loss coverage will be established by applying calculated losses to a nominal loss coverage ratio scale within the limits of pool allocations to public and non-public agencies. Notwithstanding any inconsistent provisions of this paragraph, adjustments to rates of payment for diagnostic and treatment centers determined in accordance with this paragraph shall apply only for services provided on or before December 31, 1996.

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Supersedes TN 95-25 Effective Date APR - 1 1996

Attachment 4.19B
(6/96)

Laboratory Services

Fee Schedule developed by Department of Health and approved by Division of the Budget. In compliance with Section 2303 of the Deficit Reduction Act of 1984, on the aggregate, Medicaid fees for clinical diagnostic laboratory tests are not to exceed those amounts recognized by Medicare.

Home Health Services/Certified Home Health Agencies

Prospective, cost based hourly and per visit rates for five services shall be calculated by the Department of Health and approved by Division of the Budget. Rates are based on the lower of cost or ceiling, trended, or, if lower, the charge. Providers are grouped geographically into upstate/downstate and by sponsorship, public/voluntary. Ceilings are calculated using the group cost experience. For purposes of establishing rates of payment by governmental agencies for certified home health agencies for the period April first, nineteen hundred ninety-five through December 31, 1995 and for rate periods beginning on or after January 1, 1996, the reimbursable base year administrative and general costs of a provider of services, excluding a provider of services reimbursed on an initial budget basis, and a new provider, excluding changes in ownership or changes in name, who begins operations in the year prior to the year which is used as base year in determining rates of payment, shall not exceed the statewide average of total reimbursable base year administrative and general costs of such providers of services. In the 1996 and 1997 rate periods, respectively, the amount of such reduction in certified home health agency rates of payments made during the twelve month period running from April 1[, 1995] of the year prior to the respective rate period through March 31[, 1996] of such respective rate period shall be adjusted in the [1996] respective rate period on a pro-rate basis, if it is determined upon post-audit review by June 15[, 1996] of the respective rate period and reconciliation, that the savings for the state share, excluding the federal and local government shares, of medical assistance payments is in excess of one million five hundred thousand dollars for payments made on or before March 31[, 1996], of the applicable twelve month period to reflect the amount by which such savings are in excess of or lower than one million five hundred thousand dollars.

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Supersedes TN 95-25 Effective Date APR - 1 1996

Attachment 4.19B
(6/96)

Clinic Services for Federally Qualified Native American Health Centers not subject to licensure under Article 28 of the State Public Health Law

Reimbursement for federally qualified health centers located on Native American reservations and operated by Native American tribes or tribal organizations pursuant to applicable Federal law and for which State licensure is not required will be established consistent with the methodology applicable to freestanding diagnostic and treatment centers, including federally qualified health centers which are licensed under Article 28 of the State Public Health Law. The reimbursable base year administrative and general costs of a provider, excluding a provider reimbursed on an initial budget basis, shall not exceed the statewide average of total reimbursable base year administrative and general costs of diagnostic and treatment centers. For the purposes of this provision, reimbursable base year administrative and general costs shall mean those base year administrative and general costs remaining after application of all other efficiency standards, including, but not limited to, peer group cost ceilings or guidelines. The limitation on reimbursement for provider administrative and general expenses shall be expressed as a percentage reduction of the operating cost component of the rate promulgated for each diagnostic and treatment center with base year administrative and general costs exceeding the average. Prospective all inclusive rates of payment will be calculated by the Department of Health, based on the lower of allowable average operating cost per visit or the group ceiling trended to the current year as permitted by law, except that rates of payment for the period ending September 30, 1995 shall continue in effect [~~through September 30, 1996~~] thereafter. The facilities will be compared with other facilities offering similar types of services. The rates will include a capital component which is not subject to ceiling limitations. Rates are subject to approval of the Division of the Budget. The facilities will be required to forward to the Department of Health on an annual basis any necessary financial and statistical information.

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